



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Xuan Tran, M.D.

Respondent Name

TPCIGA for Freestone Insurance Company

MFDR Tracking Number

M4-16-2733-01

Carrier's Austin Representative

Box Number 50

MFDR Date Received

May 9, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED TO DATE"

Amount in Dispute: \$1800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TPCIGA has processed the date of service in question according to the Division of Workers' Compensation Guidelines and Chapter 462."

Response Submitted by: Texas Property & Casualty Insurance Guaranty Association

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 27, 2015	Designated Doctor Examination	\$1800.00	\$300.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - Charge exceeds Fee Schedule allowance
 - P12 – Workers compensation jurisdictional fee schedule adjustment.

- Notes: “ONLY THE MMI PORTION OF THE EXAM IS BEING REIMBURSED (\$350.00). FOR THE IR PORTION, ONLY MUSCULOSKELETAL BODY AREAS SHOULD BE BILLED UNDER 99456. BASED ON THE DIAGNOSIS CODES AND DOCUMENTATION, ONLY NON-MUSCULOSKELETAL AREAS WERE REVIEWED DURING THIS EXAM. NON-MUSCULOSKELETAL AREAS SHOULD BE BILLED AND REIMBURSED USING THE APPROPRIATE CPT CODE(S) FOR THE TEST(S).

Issues

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204(j)(3), “The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.” The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is \$350.00.

28 Texas Administrative Code §134.204(j)(4)(D) states that:

Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR.

(i) Non-musculoskeletal body areas are defined as follows:

- (I) body systems;
- (II) body structures (including skin); and,
- (III) mental and behavioral disorders.

(ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.

(iii) ...

(iv) When there is no test to determine an IR for a non-musculoskeletal condition:

- (I) The IR is based on the charts in the AMA Guides. These charts generally show a category of impairment and a range of percentage ratings that fall within that category.
- (II) The impairment rating doctor must determine and assign a finite whole percentage number rating from the range of percentage ratings.
- (III) Use of these charts to assign an IR is equivalent to assigning an IR by the DRE method as referenced in subparagraph (C)(ii)(I) of this paragraph.

(v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150 [emphasis added].

Review of the submitted documentation finds that the requestor provided impairment ratings for the digestive system and mental/behavioral disorders. Therefore, the correct MAR for these examinations is \$300.00.

28 Texas Administrative Code §134.204(j)(4)(B) states,

When multiple IRs are required as a component of a designated doctor examination ... the designated doctor shall bill for the number of body areas rated and be reimbursed \$50 for each additional IR calculation. Modifier ‘MI’ shall be added to the MMI evaluation CPT code.

The submitted documentation indicates that the Designated Doctor was ordered to address Maximum Medical Improvement, Impairment Rating, and Extent of Injury. The narrative report and enclosed forms support that these examinations were performed, and 2 additional impairment ratings were provided. Therefore, the correct MAR for this service is \$100.00. The requestor is seeking \$50.00 for this service. For this reason, the total allowable is \$50.00.

Per 28 Texas Administrative Code §134.204(k),

The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the

examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with subsection (i) of this section and shall include Division-required reports...

The submitted documentation indicates that the Designated Doctor performed an examination to determine the extent of the compensable injury. Therefore, the correct MAR for this examination is \$500.00.

2. The total MAR for the disputed services is \$1200.00. Per the explanation of benefits dated June 3, 2016, the insurance carrier paid \$900.00. An additional reimbursement of \$300.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	July 28, 2016 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.